EPSRx A CarePartners Pharmacy Company | CarePartners Specialty Infusion

Phone : 844-800-5377 Fax : 214-782-9155

HEMOPHILIA & BLEEDING DISORDERS ENROLLMENT FORM

Referral Date: | Ship to: ☐ Home ☐ Office ☐ Other _____

PATIENT INFORMATION

Patient Name: | Date of Birth: | Gender:

Home Phone: | Cell Phone: | Email:

Address: | City: | State: | Zip:

Emergency Contact: | Emergency Phone:

INSURANCE INFORMATION

Please fax copy of prescription and insurance cards with this form if available (front and back)

Primary Insurance: _____

ID #: _____ Group #: _____

Secondary Insurance: _____

ID #: _____ Group #: _____

Prescription Card ID: _____ BIN #: _____

PCN #: _____ Group #: _____

PRESCRIBER INFORMATION

Prescriber Name: _____

DEA #: _____ NPI #: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Contact Person: _____

DIAGNOSIS

- ☐ D66 - Hemophilia A (Factor VIII Deficiency)
- ☐ D67 - Hemophilia B (Factor IX Deficiency)
- ☐ D68.1 - Hemophilia C (Factor XI Deficiency)
- ☐ D68.2 - Hereditary Deficiency of other Clotting Factors
- ☐ D68.0 - Von Willebrand's Disease
- ☐ D69.9 - Hemorrhagic Condition, Unspecified
- ☐ D68.4 - Acquired Coagulation Factor Deficiency
- ☐ D68.8 - Other Specified Coagulation Defects
- ☐ Other: _____

PATIENT EVALUATION

Patient Weight: _____ ☐ kg ☐ lbs

Patient Height: _____ ☐ cm ☐ in

Allergies: _____

Inhibitor: ☐ No ☐ Historical ☐ Current

Current Medications: _____

Factor Deficiency: ☐ Severe (<1%) ☐ Moderate (1-5%) ☐ Mild (>5%)

Line Access: ☐ Port ☐ PICC ☐ PIV ☐ Butterfly ☐ Other: _____

Injection Training/Home Health RN visit is necessary: ☐ Yes ☐ No

Site of Care: ☐ Home ☐ MD Office ☐ Other: _____

PRESCRIPTION INFORMATION

RX to include diluents, needles, syringes, ancillary supplies, home medical equipment to administer infusion.

Factor VIII	☐ Advate®	☐ Adynovate®	☐ Afstyla®	☐ Alphanate®	☐ Altuviiio®	☐ Corifact®
	☐ Eloctate®	☐ Esperoct®	☐ Hemofil® M	☐ Humate-P®	☐ Jivi®	☐ Koate-DVI®
	☐ Kovaltry®	☐ NovoEight®	☐ Nuwiq®	☐ Recombinate®	☐ Tretten®	☐ Vonvendi®
	☐ Wilate®	☐ Xyntha®	☐ Xyntha Solofuse®			
Factor IX	☐ AlphaNine®	☐ Alprolix®	☐ Benefix®	☐ Idelvion®	☐ Ixinity®	☐ Profilnine® ☐ Rebinyn® ☐ Rixubis®
Factor X	☐ Coagadex®					
Inhibitor Therapies	☐ Feiba® NF	☐ NovoSeven®	☐ Sevenfact®			

Dose and Directions

☐ **Prophylaxis:** Infuse _____ units (+/- _____%) slow IV-push every _____

☐ **Breakthrough Bleed:** For bleeding episodes: Infuse _____ units (+/- _____%) slow IV-push _____ for a total of _____ doses.

For minor bleeds: Infuse _____ IU every _____

For major bleeds: Infuse _____ IU every _____

☐ **Other:** _____

	Quantity	Refills
# of Prophy Doses		
# of PRN Doses		

Subcutaneous

☐ Alhemo®

Dose and Directions

☐ 60mg/1.5mL PEN ☐ 150mg/1mL PEN

☐ Loading Dose: Inject _____ subcutaneously once on Day 1, followed by _____ mg subcutaneously once daily until individualization of maintenance dose.

☐ Maintenance Dose: Inject _____ mg subcutaneously once daily.

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		Dose and Directions	Quantity	Refills
Subcutaneous	☐ Hemlibra®	☐ 12mg/0.4mL ☐ 30mg/mL ☐ 60mg/0.4mL ☐ 105mg/0.7mL ☐ 150mg/1mL ☐ 300mg/2mL ☐ Initial dose: 3mg/kg subcutaneously once weekly for 4 weeks ☐ Maintenance dose: ☐ 1.5mg/kg subcutaneously every week ☐ 3mg/kg subcutaneously every 2 weeks ☐ 6mg/kg subcutaneously every 4 weeks		
	☐ Hympavzi®	**Dose and Directions** ☐ 150mg/mL PFS ☐ 150mg/mL PEN ☐ Loading Dose: Inject 300mg (two 150mg injections) subcutaneously once ☐ Maintenance Dose: Inject 150mg subcutaneously every week		
Other				
Flush Protocol	☐ NaCl 0.9% 5mL ☐ NaCl 0.9% 10mL ☐ Heparin 10 units per mL ☐ Heparin 100 units per mL	Use as needed before/after infusion to maintain IV access and patency, or as final flush.		
Other Medication	☐ Amicar® Tablet/Syrup Directions: _____			
	☐ Lidocaine 2.5%/Prilocaine 2.5% Cream (May dispense Lidocaine 4%) Directions: Apply to injection site(s) at least 1 hour prior to needle insertion.			
Additional Orders				

PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

By signing this form and using this pharmacy's services, you are authorizing this pharmacy to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies.

☐ May Substitute/Product Selection Permitted/Substitution Permissible
Prescriber Signature _____ **Date** _____

☐ Dispense as Written/Brand Medically Necessary/Do Not Substitute/No Substitution/May Not Substitute
Prescriber Signature _____ **Date** _____

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "**No Substitution**" _____ **NY & Iowa** providers, please submit electronic prescription.